CHECKLIST TO DETERMINE ACCREDITING AUTHORITY COMPLIANCE

AA Applicant Name: _____

_____

NELAP Certificate No. _____

Date Reviewed: / /

Reviewed By _____

NELAP Accrediting Authority Applicant: Please complete all numbered items, indicating the location of the information in the application package. Shaded area is for use only by the NELAP assessment team.

Note: Based on 1999 NELAC Standards: Most NELAC requirements identified on this checklist are a paraphrase of the NELAC standard. The number preceding each checklist item is the location in the NELAC standards where the exact language for that requirement can be found.

	NELAC Requirements of an Accrediting Authority				
	AA: Date:	**Yes**	**No**	**NA**	**Document Location/Comments**
	A. The accrediting authority's program requires accredited laboratories to meet the following NELAC standards:				
1.	2.2.**3** Laboratories that seek to become accredited or maintain accreditation shall perform analyses of PT samples for each PT field of testing for which NELAP accreditation is sought. The laboratory must obtain PT samples from any NELAP designated PTOB/PTPA-approved PT Provider. The results of the analyses shall be submitted to the PT Provider for scoring.				
2.	2.4.1 To be accredited initially and to maintain accreditation, a laboratory shall participate in two single-blind, single concentration PT studies, where available, per year for each PT field of testing for which it seeks or wants to maintain accreditation. Each laboratory shall participate in at least two PT studies for each PT field of testing per year unless a different frequency for a given program is defined in the appendices.				
3.	2.5 The laboratory's management and all analysts shall ensure that all PT samples are handled (i.e., managed, analyzed, and reported) in the same manner as real environmental samples utilizing the same staff, procedures, equipment, facilities, and frequency of analysis for PT samples as for real environmental samples.				
4.	2.5.1 (a) A laboratory shall not send any PT sample, or a portion of a PT sample, to another laboratory for any analysis for which it seeks accreditation, or is accredited.				
5.	2.5.1 (b) A laboratory shall not knowingly receive any PT sample or portion of a PT sample from another laboratory for any analysis for which the sending laboratory seeks accreditation, or is accredited.				
6.	2.5.1 (c) Laboratory management or staff shall not communicate with any individual at another laboratory (including intracompany communication) concerning the PT sample.				
7.	2.5.1 (d) Laboratory management or staff shall not attempt to obtain the assigned value of any PT sample from their PT Provider.				
8.	2.5.2 The laboratory shall maintain copies of all written, printed, and electronic records, including but not limited to bench sheets, instrument strip charts or printouts, data calculations, and data reports, resulting from the analysis of any PT sample for five years or for as long as is required by the applicable regulatory program, whichever is greater. These records shall include a copy of the PT study report forms used by the laboratory to record PT results. All of these laboratory records shall be made available to the assessors of the Primary Accrediting Authority during on-site audits of the laboratory.				
9.	2.7.2 A laboratory which seeks accreditation shall successfully complete two PT studies for each requested PT field of testing within the most recent three rounds attempted.				

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10.	2.7.2 When a laboratory has been granted accreditation status, it shall continue to complete PT studies for each PT field of testing and maintain a history of at least two acceptable PT studies for each PT field of testing out of the most recent three.				
11.	2.7.2 For initial accreditation or supplemental testing, the PT studies shall be at least 30 calendar days apart.				
12.	2.7.2 For continuing accreditation, completion dates of successive proficiency rounds for a given PT field of testing shall be approximately six months apart. Failure to meet the semiannual schedule is regarded as a failed study.				
13.	2.7.3 A laboratory may elect to participate in PT studies more frequently than required by the semiannual schedule. These additional studies are not distinguished from the routinely scheduled studies; that is, they shall be reported and are counted and scored the same way and shall be at least 30 calendar days apart.				
14.	2.7.4 Whenever a laboratory fails a PT study, it shall determine the cause for the failure and take any necessary corrective action. It shall then document in its own records both the investigation and the action taken.				
15.	2.7.7 A laboratory may withdraw from a PT study for an analyte(s) or for the entire study if the laboratory notifies both the PT Provider and the Primary Accrediting Authority before the closing date of the PT study. This does not exempt the laboratory from participating in the semiannual schedule.				
16.	3.5.2 A laboratory's refusal to admit the assessment team for an assessment will result in an automatic failure of the laboratory to receive accreditation or loss of an existing accreditation by the laboratory, unless there are extenuating circumstances that are accepted and documented by the accreditation authority.				
17.	4.1.1.1 The laboratory must identify its technical director. The technical director means a full-time member of the staff of an environmental laboratory who exercises actual day-to-day supervision of laboratory procedures and reporting of results.				
18.	4.1.1.1 A technical director who is absent for a period of time exceeding 15 consecutive calendar days shall designate another full-time staff member meeting the qualifications of technical director to temporarily perform this function. If this absence exceeds 65 consecutive calendar days, the accrediting authority shall be notified in writing.				
19.	4.1.1.1 The required qualifications of a technical director are found in Chapter Four, section 4.1.1.1 (a) through (f) and exemption language in section 4.1.1.2.				
20.	4.1.3 (b) After being notified of deficiencies, the laboratory shall have 30 calendar days from the date of receipt of the assessment report to provide a corrective action report.				

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21.	4.1.3 (d) If the corrective action report (or a portion) is deemed unacceptable to remediate a deficiency, the laboratory shall have an additional 30 calendar days to submit a revised corrective action report.				
22.	4.1.5 (a) Each accredited laboratory shall have a named Quality Assurance Officer or a person designated as accountable for data quality. (See NELAC Chapter 5, subsection 5.4.2 (g) for specific requirements)				
23.	4.1.5 (b) Each accredited laboratory shall have a Quality Manual. (See NELAC Chapter 5, subsection 5.5.2 for specific requirements)				
24.	4.1.8 (e) Where there is a change in ownership All records and analyses performed pertaining to accreditation must be kept for a minimum of 5 years and are subject to inspection by the accrediting authorities during this period without prior notification to the laboratory. This stipulation is applicable regardless of change in ownership, accountability or liability.				
25.	4.3.2 The accredited laboratory shall notify the accrediting authority of any changes in key accreditation criteria within 30 calendar days of the change. This written notification of change includes but is not limited to: the laboratory ownership, location, key personnel, and major instrumentation.				
26.	4.6 The certificate must be returned to the accrediting authority upon loss of accreditation. However, this does not require the return of a certificate which has simply expired (reached the expiration date).				
27.	5.0 The laboratories must meet all the requirements set forth in NELAC, Chapter 5. Verification and documentation of this must be accomplished by comparison of the applicant accrediting authority's program requirements with the Chapter 5 checklist. The NELAP assessment team must note on the checklist that each Chapter 5 requirement is addressed by the applicant accrediting authority's program.				
28.	6.8(a)(1) NELAP accredited laboratories must post or display their most recent NELAP accreditation certificate or their NELAP accreditation fields of testing in a prominent place in the laboratory facility.				
29.	6.8 (a)(2) NELAP accredited laboratories must make accurate statements concerning their NELAP accreditation fields of testing and NELAP accreditation status.				
30.	6.8 (a)(3) NELAP accredited laboratories accompany the accrediting authority’s name and/or the NELAC/NELAP logo with at least the phrase “NELAP accredited” and the laboratory’s accreditation number or other identifier when the accrediting authority’s name is used on general literature such as catalogs, advertising, business solicitations, proposals, quotations, laboratory analytical reports or other materials.				

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31.	6.8 (a)(4) NELAP accredited laboratories not use their NELAP certificate, NELAP accreditation status and/or NELAC/NELAP logo to imply endorsement by the accrediting authority.				
	B. The accrediting authority's program must meet the following NELAC standards:				
32.	2.7.5 Second Failed Study, If a laboratory fails a second PT study, the accrediting authority shall take action within 60 days to determine the accreditation status of all methods for the unacceptable analyte(s) for that program and matrix.				
33.	2.7.6 A Primary Accrediting Authority may specify which months that laboratories within its authority are required to participate in NELAC PT programs. If the Primary Accrediting Authority chooses to specify the months, then it shall adhere to the required semiannual schedule. If the Primary Accrediting Authority does not specify the months, then the laboratory shall determine the semiannual schedule.				
34.	3.2.1 A laboratory assessor may work for a Federal, State, or a third party assessor body.				
35.	3.2.1 Each assessor also must have satisfactorily completed an approved assessor training program. All assessors must take annual update/refresher training as specified by the NELAC.				
36.	3.2.1 An assessor must be an experienced professional and hold at least a B.S. degree in a basic science, or have equivalent education and experience in laboratory assessment or related fields.				
37.	3.2.1 Each new candidate assessor must undergo training with a qualified assessor during four or more actual assessments until judged proficient by the accrediting authority. Assessors employed by accrediting authorities (either directly or as a third party) when the authority is granted NELAP recognition (see section 6.7) are exempt from the requirement to undergo training with a qualified assessor during four or more actual on-site assessments, provided they have previously conducted four assessments and been judged proficient by the accrediting authority.				
38.	3.2.1 Assessors employed by accrediting authorities on the date that the first Accrediting Authority is granted NELAP recognition must meet the NELAC-specified basic training course requirements within two years after the first NELAC-specified basic training course is offered and the applicable technical training course requirements within four years after the first NELAC-specified technical training course is offered.				
	3.2.1 The accrediting authority has demonstrated that its assessors:				
39.	3.2.1 (a) Be familiar with the relevant legal regulations, accreditation procedures, and accreditation requirements;				

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40.	3.2.1 (b) Have a thorough knowledge of the relevant assessment methods and assessment documents;				
41.	3.2.1 (c) Be thoroughly familiar with the various forms of records described in Section 3.5.3 - Records Review;				
42.	3.2.1 (d) Be thoroughly cognizant of data reporting, analysis, and reduction techniques and procedures;				
43.	3.2.1 (e) Be technically conversant with the specific tests or types of tests for which the accreditation is sought and, where relevant, with the associated sampling and preservation procedures; and				
44.	3.2.1 (f) Be able to communicate effectively, both orally and in writing.				
45.	3.2.2 Each assessor must sign a statement before conducting an assessment certifying that no conflict of interest exists and provide any supporting information as required by the accrediting authority. Failure to provide this information will make the proposed assessor ineligible to participate in the assessment program. (See also 6.3.3.1 (i))				
46.	3.3.1 Accrediting authorities must require a comprehensive on-site assessment of each accredited facility at least every two years. Assessments may be conducted more frequently for cause, at the option of the accrediting authority.				
47.	3.3.3 The accrediting authority may also deem necessary an assessment when a major change occurs at a laboratory in personnel, equipment, or in a laboratory's location that might alter or impair analytical capability and quality.				
48.	**3.3.4The accrediting authority, at its discretion, may conduct either unannounced or announced on-site assessments. The accrediting authority is not required to provide advance notice of an assessment. To the maximum extent practical, accrediting authorities, when necessary, shall work with Federal departments/agencies/contractors to obtain government security clearances for their assessors as far in advance as possible. Federal departments/agencies/ contractors shall facilitate expeditious attainment of the necessary clearances.**				
49.	3.4.2 The on-site assessment must include both an appraisal of the laboratory's operations and a review of the appropriate records.				
50.	3.4.2.1 A laboratory assessment must review the ability of the laboratory to conduct environmental testing.				

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51.	3.4.2.2 The accrediting authority reviews records to determine whether the testing laboratory has maintained necessary documentation of data and other information to technically substantiate reports previously issued. During a records review, the assessment team will conduct an overall audit of data and will compare data with submitted reports to determine whether the data were collected, generated, and reported following the NELAC standards.				
52.	3.4.3 The accrediting authority, prior to initiating an on-site assessment, shall make determinations as to which laboratory records shall be reviewed prior to the actual site visit.				
53.	3.4.5 The accrediting authority has procedures in place for treating confidential business information in a safe and secure manner.				
54.	3.4.6 Assessors performing assessments at facilities owned and/or operated by Federal departments/ agencies/ contractors may need security clearances, appropriate badging, and/or a security briefing before proceeding with the on-site assessment. Assessors shall be informed in writing of any information, including analytical data, that is controlled for national security reasons and cannot be released to the public.				
	3.5.2 An opening conference must be conducted and shall address the following topics:				
55.	3.5.2 (a) the purpose of the assessment;				
56.	3.5.2 (b) the identification of the assessment team;				
57.	3.5.2 (c) the tests that will be examined;				
58.	3.5.2 (d) any pertinent records and operating procedures to be examined during the assessment and the names of the individuals in the laboratory responsible for providing the assessment team with the necessary documentation;				
59.	3.5.2 (e) the roles and responsibilities of key managers and staff in the laboratory;				
60.	3.5.2 (f) the procedures related to Confidential Business Information;				

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61.	3.5.2 (g) any special safety procedures that the laboratory may think necessary for the protection of the assessment team while in certain parts of the facility (under no circumstance is an assessment team required or even allowed to sign any waiver of responsibility on the part of the laboratory for injuries incurred by a team member during an inspection to gain access to the facility);				
62.	3.5.2 (h) the standards that will be used by the assessors in judging the adequacy of the laboratory operation;				
63.	3.5.2 (i) confirmation of the tentative time for the exit conference;				
64.	3.5.2 (j) provision of the assessment appraisal form to the responsible laboratory official (to be submitted to NELAP and the accrediting authority); and				
65.	3.5.2 (k) discussion of any questions the laboratory may have about the assessment process.				
	3.5.3 A minimum record set that must be examined as part of a accreditation assessment includes:				
66.	3.5.3 (a) application for accreditation from the laboratory;				
67.	3.5.3 (b) previous assessment results and reports including proficiency testing results;				
68.	3.5.3 (c) laboratory management structure and chains of responsibility (e.g. organizational charts);				
69.	3.5.3 (d) qualification statements of all key staff involved in the analysis or reporting of results for which accreditation has been requested and a matching of the staff qualifications with the statements submitted with the applications;				
70.	3.5.3 (e) quality manual(s) for the laboratory;				
71.	3.5.3 (f) standard operating procedures and methodologies for each parameter for which accreditation is sought;				
72.	3.5.3 (g) maintenance and calibration records of laboratory equipment and instrumentation;				
73.	3.5.3 (h) procedures for the make-up and calibration of stock solutions and standard reagents;				

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74.	3.5.3 (i) origins, purities, assays and expiration dates of primary standards, analytical reagents and standard reference materials;				
75.	3.5.3 (j) records associated with method-specific QA\QC requirements;				
76.	3.5.3 (k) the specific records associated with the initial method validation study in the laboratory which must be examined in detail with the historical calibration data;				
77.	3.5.3 (l) records associated with the methods used to estimate precision and accuracy in general for specific analyses;				
78.	3.5.3 (m) sample receipt and handling documentation;				
79.	3.5.3 (n) proficiency testing sample receipt and handling procedures;				
80.	3.5.3 (o) information about the proficiency testing providers;				
81.	3.5.3 (p) records of any internal audits conducted and/or corrective actions taken by the laboratory itself; and				
82.	3.5.3 (q) the report of the laboratory's annual management review.				
83.	3.5.4 The assessment team members shall have the authority to conduct interviews with any/all staff, as necessary.				
84.	3.5.5 The assessment team must meet with representative(s) of the laboratory following the assessment for an informal debriefing and discussion of findings with the possible exception of any issues of improper and/or potentially illegal activity which may be the subject of further action.				
85.	3.5.6 & 3.7.2 The final site visit report shall be written to contain a description of the adequacy of the laboratory as it relates to the assessment standards in Section 3.6.4. Deficiencies must be addressed at a minimum. (See also 4.1.3 (b))				
86.	3.7.3 Distribution The accrediting authority shall be recognized as having the responsibility for the distribution of the assessment reports.				

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87.	3.7.4 Release of Report On-site assessment reports should be released initially by the accrediting authority only. The reports will be released to the responsible laboratory official(s). The assessment report shall not be released to the National Accreditation Database and the public until findings of the assessment and the corrective actions have been finalized, all Confidential Business Information and information related to national security has been stricken from the report in accordance with prescribed procedures, and the report has been provided to the laboratory (Section 4.1.3). In accordance with the Freedom of Information requirements, any documentation adjudged to be proprietary, financial and/or trade information, or relevant to an ongoing enforcement investigation, will be considered exempt from release to the public.				
	3.7.2 Assessment reports shall contain:				
88.	3.7.2 (a) Identification of the organization assessed (name and address),				
89.	3.7.2 (b) Date of the assessment,				
90.	3.7.2 (c) Identification and affiliation of each assessment team member,				
91.	3.7.2 (d) Identification of participants in the assessment process,				
92.	3.7.2 (e) Statement of the objective of the assessment,				
93.	3.7.2 (f) Summary,				
94.	3.7.2 (g) Assessment findings (deficiencies) and requirements, and				
95.	3.7.2 (h) Comments and recommendations.				
96.	3.7.2 The Findings and Requirements Section must be referenced to a NELAC standard so that both the finding (deficiency) is understood and the specific requirement is outlined.				

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97.	3.5.7 Assessment Closure After reviewing the assessor's report(s) and any completed corrective action(s) reported by the laboratory, the accrediting authority will make the determination of the accreditation status for a laboratory. If the deficiencies listed are substantial or numerous, an additional on-site assessment may be conducted before a final decision for accreditation can be made.				
98.	3.6.1 The accrediting authority must ensure that its assessors are trained as set forth in the NELAC Assessor Training Manual and these procedures are used in carrying out the on-site assessment.				
99.	3.6.3 NELAC-approved standardized checklists must be used for the on-site assessment. 3.7.1 The checklists used by the assessors during the assessment shall become a part of the permanent file kept by the accrediting authority for each laboratory.				
100.	3.7.5 Copies of all assessment reports, checklists, and laboratory responses must be retained by the assessors and the accrediting authority for a period of at least ten years, or longer if required by specific State or Federal regulations. (See also 6.3.3.1.1(b))				
101.	4.1.2 On-Site Assessments- Covered by NELAC Chapter 3.				
	4.1.3 Corrective Action Reports In Response to On-Site Assessment,				
102.	4.1.3 (a) The accrediting authority shall present a assessment report to the laboratory within 30 calendar days of the on-site assessment.				
103.	4.1.3 (c) The accrediting authority shall respond to the action noted in the corrective action report within 30 calendar days of receiving it.				
104.	4.1.3 (e) If the corrective action report is not acceptable to the accrediting authority after the second submittal, the laboratory's accreditation shall be revoked pursuant to Section 4.4.3 for all or any portion of its scope of accreditation.				
105.	4.1.3 (g) If the laboratory fails to implement corrective actions to correct deficiencies noted within the required time period, the accrediting authority shall revoke the laboratory's accreditation for the affected fields of testing, methods and analytes.				
106.	4.1.4 Proficiency Testing Sample- Covered by NELAC Chapter 2.				
	4.1.7 An accrediting authority must include in its application form the following:				
107.	4.1.7 (a) Legal name of laboratory				

	NELAC Requirements of an Accrediting Authority				
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108.	4.1.7 (b) Laboratory mailing address				
109.	4.1.7 (c) Billing address (if different from b)				
110.	4.1.7 (d) Name of owner				
111.	4.1.7 (e) Address of owner				
112.	4.1.7 (f) Location (full address) of laboratory				
113.	4.1.7 (g) Name and phone number of technical director(s), however named, and the lead technical director				
114.	4.1.7 (h) Name and phone number of Quality Assurance Officer				
115.	4.1.7 (i) Name and phone number of laboratory contact person				
116.	4.1.7 (j) Laboratory hours of operation				
117.	4.1.7 (k) Primary Accrediting Authority				
118.	4.1.7 (l) Fields of Testing for which the laboratory is requesting accreditation				
119.	4.1.7 (m) Methods employed including analytes				
120.	4.1.7 (n) Description of laboratory type				
121.	4.1.7 (o) Certification of compliance by laboratory management				
122.	4.1.7 (p) Applicable fee enclosed (if applicable)				

	NELAC Requirements of an Accrediting Authority				
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123.	4.1.7 (q) Description of geographical location				
124.	4.1.7 (r) FAX number				
125.	4.1.7 (s) Lab identification number				
126.	4.1.7 (t) Quality Manual				
127.	4.1.7 The accrediting authority must have procedures in place for laboratory accreditation renewal.				
128.	4.1.8 The accrediting authority must have procedures in place for addressing the change of ownership and/or location of an accredited laboratory that meet the requirements set forth in this subsection.				
129.	4.1.9 A "Certification of Compliance" statement must accompany the application for laboratory accreditation. It must be signed and dated by both the laboratory management and the quality assurance officer, or other designated person, for that laboratory. The certification statement must contain at least the following statements:				
130.	4.1.9 "The applicant understands and acknowledges that the laboratory is required to be continually in compliance with the (insert the name of the primary accrediting authority) standards and is subject to the enforcement and penalty provisions of that accrediting authority.				
131.	4.1.9 "I hereby certify that I am authorized to sign this application on behalf of the applicant/owner and that there are no misrepresentations in my answer to the questions on this application."				
132.	4.2 The period for accreditation will be 12 months and will be considered to be ongoing once a laboratory has been accredited for that field of testing method or analyte within a field of testing and is compliant with the NELAC standards.				
133.	4.3.1 Quality Systems- Covered by NELAC Chapter 5.				
	4.4.1 An accrediting authority shall *deny* an initial application for accreditation for the following reasons:				
134.	4.4.1 (a)(1) Failure to submit a completed application.				

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135.	4.4.1 (a)(2) Failure of laboratory staff to meet the personnel qualifications of education, training and experience as required by the NELAC standards.				
136.	4.4.1(a)(3) Failure to successfully analyze and report proficiency testing samples as required by the NELAC standards, Chapter 2.				
137.	4.4.1 (a)(4) Failure to respond to an assessment report from the on-site assessment with a corrective action report within the required 30 calendar days after receipt of the assessment report.				
138.	4.4.1 (a)(5) Failure to implement the corrective actions detailed in the corrective action report within the specified time frame as required by the primary accrediting authority.				
139.	4.4.1 (a)(6) Failure to pay required fees (if applicable to the accrediting authority).				
140.	4.4.1 (a)(7) Failure to pass required on-site assessment(s) as specified in the NELAC standards, Chapter Three.				
141.	4.4.1 (a)(8) Misrepresentation of any material fact pertinent to receiving or maintaining accreditation.				
142.	4.4.1 (a)(9) Denial of entry during normal business hours for an on-site assessment as required by the NELAC standards, Chapter 3.				
143.	4.4.1 (b) If the laboratory is not successful in correcting the deficiencies as required by the NELAC standards, the accrediting authority shall make the laboratory wait six months before again reapplying for accreditation.				
144.	4.4.1 (d) No laboratory's accreditation will be denied without the right to due process as set forth by the accrediting authority.				
	4.4.2 (a) & 4.4.2 (b) An accrediting authority shall *suspend* a laboratory's accreditation in total or in part and an accrediting authority shall suspend a laboratory's accreditation for the following reasons:				
145.	4.4.2 (b)(1) If the primary accrediting authority finds during the on-site assessment that the public interest, safety or welfare imperatively requires emergency action.				
146.	4.4.2 (b)(2) Failure to complete PT studies and maintain a history of at least two successful PT studies for each affected accredited field of testing (as defined in NELAC, Chapter 2) out of the most recent three PT studies.				
147.	4.4.2 (b)(3) Failure to notify the accrediting authority of any changes in key accreditation criteria, as set forth in subsection 4.3.2.				

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148.	4.4.2 (e) The accrediting authority does not require a suspended laboratory to reapply for accreditation if the cause/causes for suspension are corrected within six months.				
149.	4.4.2 (c) The accrediting authority does not allow a suspended laboratory to continue to analyze samples for the affected fields of testing for which it holds accreditation.				
150.	4.4.2 (d) The laboratory's suspended accreditation status will change to accredited when the laboratory demonstrates to the primary accrediting authority that the laboratory complies with the NELAC standards.				
151.	4.4.2 (g) No laboratory's accreditation shall be suspended without the right to due process as set forth by the accrediting authority.				
152.	4.4.3 (a) The accrediting authority shall revoke a laboratory's accreditation, in part or in total for failure to correct the deficiencies as set forth in subsection 4.1.3 (e) and failure to correct reasons for suspension. The laboratory shall retain those areas of accreditation where it continues to meet the requirements of the NELAC standards.				
	4.4.3 (b) Reasons for revocation of accreditation in part or in total shall include a laboratory's:				
153.	4.4.3 (b)(1) Failure to submit an acceptable corrective action report, in response to an assessment report.				
154.	4.4.3 (b)(1) Failure to implement corrective action(s) related to any deficiencies found during a laboratory assessment.				
	4.4.3 (c) Reasons for total revocation of accreditation include a laboratory's:				
155.	4.4.3 (c)(1) Failure to respond with a corrective action report within the required 30 calendar days.				
156.	4.4.3 (c)(2) Failure to participate in a proficiency testing program as required by the NELAC standards, Chapter 2.				
157.	4.4.3 (c)(3) Submitting proficiency test sample results generated by another laboratory as its own.				
158.	4.4.3 (c)(4) Misrepresentation of any material fact pertinent to receiving or maintaining accreditation.				
159.	4.4.3 (c)(5) Denial of entry during normal business hours for an on-site assessment.				
160.	4.4.3 (c)(6) Conviction of charges for the falsification of any report of or relating to a laboratory analysis.				

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161.	4.4.3 (c)(7) Failure to remit the accreditation fees (if applicable to the accrediting authority) within the time limit as established by the accrediting authority.				
162.	4.4.3 (d) After correcting the reason/cause for revocation, the accrediting authority shall allow the laboratory to reapply for accreditation.				
163.	4.4.3 (e) No laboratory's accreditation will be revoked without the right to due process as set forth by the accrediting authority.				
164.	4.4.4 The accrediting authority has provisions to allow an accredited laboratory to withdraw its accreditation. The written notification to withdraw must be received by the accrediting authority no later than 30 days before the end of the laboratory's accreditation year.				
165.	4.5.1 If a laboratory completes all of the requirements for accreditation except that of an on-site assessment because the accrediting authority is unable to schedule the assessment, the accrediting authority may issue an interim accreditation. Interim accreditation shall allow a laboratory to perform analyses and report results with the same status as an accredited laboratory until the on-site assessment requirements have been completed. Interim accreditation status shall not exceed twelve months. The interim accreditation status is a matter of public record and shall be entered into the national database.				
166.	4.6 When a participating laboratory has met the requirements specified for receiving accreditation, the laboratory shall receive a certificate awarded on behalf of the accrediting authority. The certificate shall be signed by a member of the accrediting authority and shall be considered an official document. It will be transmitted as a sealed and dated (effective date and expiration date) document containing the NELAC insignia. The certificate shall include: a) name of laboratory, b) address of the laboratory, c) fields of testing (program, method, analyte), and, d) addenda or attachments (these shall be considered to be official documents).				
167.	4.6 The laboratory must have a certificate for each State or federal department/agency in which it is accredited. Even though a parent laboratory is accredited, the subfacilities (laboratories operating under the same parent organization, analytical procedures, and quality assurance system) are inspected or processed separately and shall be issued their own Certificate of Accreditation. Any subfacilities or remote laboratory sites are considered separate sites and are subject to separate announced and unannounced assessments, provided that the analysis or any portion of the analysis takes place at that site.				

	NELAC Requirements of an Accrediting Authority				
	AA: Date:	**Yes**	**No**	**NA**	**Document Location/Comments**
168.	4.6.1 The accrediting authority shall issue certificates which state that "continued accredited status depends on successful ongoing participation in the program".				
169.	4.6.1 The accrediting authority shall issue certificates shall include a statement that urges a customer to verify the laboratory's current accreditation standing within a particular accrediting authority.				
170.	4.6 If an accrediting authority changes a laboratory's scope of accreditation, a new certificate will be issued which details the laboratory's scope of accreditation.				
171.	6.2(a) The accrediting authority is a governmental organization.				
172.	6.2(b) The accrediting authority has been designated as the appropriate agency or department for the fields of testing for which NELAP recognition is being sought.				
173.	6.2(c) The authority for granting, maintaining, suspending or revoking a laboratory's NELAP accreditation resides with the accrediting authority.				
174.	6.2(d) The accrediting authority shall administered its program in an impartial and non-discriminatory manner. The accrediting authority has no rules, regulations, procedures or practices that:				
175.	6.2(d)(1) restrict the size, large or small, of any laboratory seeking accreditation.				
176.	6.2(d)(2) require membership or participation in any laboratory or other professional association.				
177.	6.2(d)(3) impose any financial conditions or restrictions for participation in the accreditation program other than the fees authorized by territorial, state or federal law.				
178.	6.2(d)(4) conflict with any territorial, state or federal laws governing discrimination.				
179.	6.2(e) The accrediting authority and its contractors shall confine their requirements, assessments and decision making processes for an accredited laboratory to those matters specifically related to the fields of testing of the accreditation being sought by a laboratory.				

	NELAC Requirements of an Accrediting Authority				
	AA: Date:	**Yes**	**No**	**NA**	**Document Location/Comments**
180.	6.2(f) The NELAP-recognized accrediting authority accompanies the display of the NELAP insignia with at least the phrase "NELAP-recognized". (Not applicable to Initial Applications)				
181.	6.2 (g) Accrediting authorities, within the scope and applicability of their prevailing rules and regulations, shall establish one or more technical committees for assistance in interpretation of requirements and for advising the accrediting authority on the technical matters relating to the operation of its environmental laboratory accreditation program.				
	When such committees are established, the accrediting authority shall have				
182.	6.2 (g)(1) formal rules and structures for the appointment and operation of committees involved in the accreditation process and such committees shall be free from any commercial, financial, and other pressures that might influence decisions, or				
183.	6.2 (g)(2) a structure where committee members are chosen to provide relevant competent technical support and impartiality through a balance of interests where no single interest predominates, and				
184.	6.2 (g)(3) a mechanism for publishing interpretations and recommendations made by these committees.				
185.	6.2.1(a) As a NELAP-recognized secondary accrediting authority, accreditation shall be granted to laboratories accredited by any other NELAP-recognized primary accrediting authority.				
186.	6.2.1(a) The NELAP-recognized accrediting authority grants such reciprocal accreditations on a laboratory-by-laboratory basis.				
187.	6.2.1(a) The NELAP-recognized secondary accrediting authority consider only the current certificate of accreditation issued by the NELAP-recognized primary accrediting authority.				
188.	6.2.1(b)(1) When granting reciprocal accreditation to a laboratory, the NELAP-recognized secondary accrediting authority grants reciprocal accreditation for only the fields of testing, methods and analytes for which the laboratory holds current primary NELAP accreditation.				
189.	6.2.1 (b)(2) When granting reciprocal accreditation to a laboratory, the NELAP-recognized secondary accrediting authority shall grant reciprocal accreditation and issue certificates, as required in NELAC, Chapter Four, to an applicant laboratory within 30 calendar days of receipt of the laboratory's application.				
190.	6.2.1(d) The NELAP-recognized secondary accrediting authority does not require any additional proficiency testing, quality assurance, or on-site assessment requirements for the fields of testing for which the laboratory holds primary NELAP accreditation.				

	NELAC Requirements of an Accrediting Authority				
	AA: Date:	**Yes**	**No**	**NA**	**Document Location/Comments**
191.	6.2.1 (e) If a NELAP-recognized secondary accrediting authority notes any potential nonconformance with the NELAC standards by a laboratory during the initial application process for reciprocal accreditation, or for a laboratory that already has been granted NELAP accreditation through reciprocity, the NELAP-recognized secondary accrediting authority shall immediately notify, in writing, the applicable NELAP-recognized primary accrediting authority and the laboratory. However, the laboratory is to be notified only in situations where no administrative or judicial prosecution is contemplated.				
192.	6.2.1 (f) Upon receipt of the subsection 6.2.1 (e) notification, the NELAP-recognized primary accrediting authority shall:				
193.	6.2.1 (f)(1) review and investigate the alleged nonconformance,				
194.	6.2.1 (f)(2) take appropriate action on the laboratory as set forth by the NELAC standards, including the addition of any change of accreditation status in the National Environmental Laboratory Accreditation Database. All such actions shall be taken in accordance with the laboratory's right to due process as set forth in the NELAC standards, Chapter Four, Accreditation Process,				
195.	6.2.1 (f)(3) respond to the NELAP-recognized secondary accrediting authority, in writing, with a copy to the NELAP Director, within 20 calendar days of receipt of the subsection 6.2.1 (e) notification providing: A) an initial report of the findings; B) a description of the actions to be taken; and, C) a schedule for implementation of further action on the alleged nonconformance, if necessary.				
196.	6.2.1 (g) If, in the opinion of the secondary accrediting authority, the primary accrediting authority does not take timely and appropriate action on the complaint, the secondary accrediting authority should notify the NELAP Director of the dispute between the two accrediting authorities regarding proper disposition of the complaint.				
197.	6.2.2 (e) In order that all laboratory applications for NELAP accreditation are treated equally, accrediting authorities shall initiate processing applications for NELAP accreditation in the chronological order that the applications are received.				
198.	6.2.3(a)(1)(A) The accrediting authority has information setting forth its authority to grant laboratory accreditations and whether such laboratory accreditation is mandatory or voluntary.				
199.	6.2.3(a)(1)(B) The accrediting authority has information setting forth its requirements for an environmental laboratory to become accredited.				
200.	6.2.3(a)(1)(C) The accrediting authority has information stating the requirements for granting, maintaining, withdrawing, suspending or revoking laboratory accreditation.				

	NELAC Requirements of an Accrediting Authority				
	AA: Date:	**Yes**	**No**	**NA**	**Document Location/Comments**
201.	6.2.3(a)(1)(D) The accrediting authority has information about the laboratory accreditation process.				
202.	6.2.3(a)(1)(E) The accrediting authority has information on fees charged to applicants and accredited laboratories.				
203.	6.2.3(a)(1)(F) The accrediting authority has information regarding the rights and duties of accredited laboratories.				
204.	6.2.3(a)(1)(G) The accrediting authority has information listing its accredited laboratories describing the accreditation granted.				
205.	6.2.3(a)(2) The accrediting authority reviews the document or documents listed in 6.2.3 (a)(1)(A through G) annually. A written record of this review is available for inspection.				
206.	6.2.3(b) The accrediting authority updates the 6.2.3(a) documents when its review reveals that the program has changed or is otherwise different within 30 days of the review.				
207.	6.2.3(c) The accrediting authority makes the 6.2.3(a) documents readily available upon request.				
208.	6.2.3 (d) The accrediting authority shall have arrangements, consistent with NELAC, Chapter Three, On-Site Assessment to safeguard information claimed by the laboratories as confidential.				
209.	6.3.3.1(b) The accrediting authority is a legally identifiable governmental entity.[See also 6.2(a) above]				
210.	6.3.3.1(c) The accrediting authority has the authority, rights and responsibilities necessary to carry out an environmental laboratory accreditation program.				
211.	6.3.3.1(d) The accrediting authority has the same arrangements to cover liabilities and workman's compensation claims arising from its operations and activities as all other programs, units, divisions, bureaus, etc. in the department or agency in which the accrediting authority is located.				

	NELAC Requirements of an Accrediting Authority				
	AA: Date:	**Yes**	**No**	**NA**	**Document Location/Comments**
212.	6.3.3.1 (e) The accrediting authority shall have financial stability and the physical and human resources required for the operation of an accrediting authority's laboratory accreditation program. The accrediting authority shall have and make available on request a description of the means by which it receives its financial support. As a benchmark, the accrediting authority shall have the resources necessary to complete action on a laboratory's application within nine months from the time a completed application is first received from the laboratory. This time period applies as long as all turn-around times for responses to application review, proficiency testing and on-site assessment issues are carried out within the required time limits set forth in the NELAC standards.				
213.	6.3.3.1(f) The accrediting authority appoints and maintain records on assessors, including contractual assessors, who meet the education, experience and training requirements set forth in the NELAC standards, Chapter three, On-Site Assessment. Such records include:				
214.	6.3.3.1(f)(1) name and address.				
215.	6.3.3.1(f)(2) organization affiliation and position held.				
216.	6.3.3.1(f)(3) educational qualification and professional status.				
217.	6.3.3.1(f)(4) work experience.				
218.	6.3.3.1(f)(5) training applicable to laboratory accreditation.				
219.	6.3.3.1(f)(6) experience in laboratory assessment, together with field of competence.				
220.	6.3.3.1(f)(7) date of most recent updating of record.				
221.	6.3.3.1(g) The accrediting authority has a system in place to evaluate assessor performance that is consistent with the organizational employee evaluation program and demonstrates compliance with the NELAC standards, Chapter three, On-Site Assessment.				
222.	6.3.3.1(h) The accrediting authority has identified one individual responsible for day-to-day management of the accrediting authority's environmental laboratory accreditation program. This individual must:				

	NELAC Requirements of an Accrediting Authority				
	AA: Date:	**Yes**	**No**	**NA**	**Document Location/Comments**
223.	6.3.3.1(h)(1) be an employee of the accrediting authority.				
224.	6.3.3.1(h)(2)(A) has the technical expertise necessary to plan and manage the laboratory accreditation program.				
225.	6.3.3.1(h)(2)(B) has the technical expertise necessary to coordinate various facets of the laboratory accreditation program with other territory, state and federal accrediting authorities.				
226.	6.3.3.1(h)(2)(C) has the technical expertise necessary to coordinate development of environmental laboratory accreditation regulations.				
227.	6.3.3.1(h)(2)(D) has the technical expertise necessary to evaluate the technical competence and performance of contractors or employees.				
228.	6.3.3.1(i) The accrediting authority has arrangements to ensure that its management and technical staff are free of any commercial, financial or other pressures that influence the results of the accreditation process .				
229.	6.3.3.1(i) The accrediting authority has arrangements to ensure that its management and technical staff are subject to the same conflict of interest disclosure requirements designed to identify and eliminate potential conflict-of- interest problems as all other programs, units, divisions, bureaus etc. in the department or agency in which the accrediting authority is located.				
230.	6.3.3.1(j) The accrediting authority has a documented procedure in place to conduct systematic internal audits annually of the accrediting authority's environmental laboratory accreditation program to verify compliance with the NELAC standards. One element of the annual internal audit shall be to review the effectiveness of the quality systems required in subsection 6.3.3.1.3. When applicable, the accrediting authority shall use the same policies and procedures for internal audits as used by all other programs, units, divisions, bureaus etc. in the department or agency in which the accrediting authority is located.				
231.	6.3.3.1(k) The accrediting authority has designated the individual specified in subsection 6.3.3.1 (h) or an individual who reports directly to the individual responsible for day-to-day management of the accrediting authority's environmental laboratory accreditation program to take responsibility for the quality system and maintenance of the quality systems manual.				
232.	6.3.3.1(l) The accrediting authority has established SOPs for dealing with appeals, complaints and disputes arising from denial, suspension or revocation of laboratory accreditation, or from users of the services about the accredited laboratories or any other matters.				
233.	6.3.3.1(m) The accrediting authority requires NELAP-accredited laboratories to participate in a proficiency testing program meeting the requirements of the NELAC standards, Chapter two, Proficiency Testing.				

	NELAC Requirements of an Accrediting Authority				
	AA: Date:	**Yes**	**No**	**NA**	**Document Location/Comments**
234.	6.3.3.1 (n) The accrediting authority or its contractors shall not offer consultancy or other services which may compromise the objectivity or impartiality of its accreditation process and decisions.				
235.	6.3.3.1.1(a) The accrediting authority has arrangements to establish and maintain records for each accredited laboratory with respect to all aspects of the laboratory's accreditation process.				
236.	6.3.3.1.1(b) The accrediting authority has a policy and procedure for retaining NELAP accreditation records for a minimum of ten years or a longer period of time if required by contractual obligations or pertinent territorial, state or federal laws and regulations.				
237.	6.3.3.1.1(c) The accrediting authority has a policy and procedures concerning access to records as prescribed by the territorial, state or federal entity in which the accrediting authority resides.				
238.	6.3.3.1.1 (d) The accrediting authority shall have a policy and procedure for updating the NELAP national database with the NELAP-required information specific to the laboratories for which that accrediting authority is the primary or secondary accrediting authority. These updates must occur no less frequently than every two weeks. The schedule for the updates would include submitting a report even if there were no changes to the database.				
239.	6.3.3.1.2(a) The accrediting authority shall have arrangements to ensure and require by signed contract or other similar type of binding document that all laboratory accreditation functions performed by a contractor on behalf of the accrediting authority are carried out in compliance with the NELAC standards.				
240.	6.3.3.1.2(b)(1) When laboratory accreditation functions are contracted out, the accrediting authority takes full responsibility for such subcontracted work.				
241.	6.3.3.1.2(b)(2) When laboratory accreditation functions are contracted out, the accrediting authority ensures that the contractor or his employees are competent and comply with the applicable provisions of the NELAC standards.				
242.	6.3.3.1.2(b)(3) When laboratory accreditation functions are contracted out, ensure that the contractor and their employees comply with the confidentiality requirements of the accrediting authority and NELAC, and,				
243.	6.3.3.1.2(b)(4)(A) When laboratory accreditation functions are contracted out, the accrediting authority ensures that the contractor and their employees are not directly involved with the laboratory seeking NELAP accreditation from the accrediting authority employing the contractor.				

	NELAC Requirements of an Accrediting Authority				
	AA: Date:	**Yes**	**No**	**NA**	**Document Location/Comments**
244.	6.3.3.1.2(b)(4)(B) When laboratory accreditation functions are contracted out, the accrediting authority ensures that the subcontractor and their employees are not directly involved with any other affiliations which would compromise impartiality in the laboratory accreditation process.				
245.	6.3.3.1.3(a) The accrediting authority has a quality system appropriate to the type, range and volume of work performed.				
246.	6.3.3.1.3(b) The accrediting authority documents its quality system in a quality manual and associated written quality procedures and makes these documents available for use by the staff. The quality manual shall include at least the following:				
247.	6.3.3.1.3(b)(1) the quality policy statement, including objectives and commitments, signed by the manager responsible for day-to-day management of the environmental laboratory accreditation program.				
248.	6.3.3.1.3(b)(2) the organizational structure of its environmental laboratory accreditation program and the responsibilities of individual staff assigned to the structure.				
249.	6.3.3.1.3(b)(3) the policies and procedures for acquiring, training, supervising and evaluating the performance of contractors carrying out any part of the accrediting authority's laboratory accreditation program.				
250.	6.3.3.1.3(b)(4) the arrangements for annual internal audits, including Quality Systems reviews, as required in subsection 6.3.3.1 (j).				
251.	6.3.3.1.3(b)(5) the system for providing feedback to personnel responsible for the area audited and for taking timely and appropriate corrective actions whenever discrepancies are detected.				
252.	6.3.3.1.3(b)(6) the procedures established to address conflict-of-interest questions arising from the NELAC standards as set forth in subsection 6.2.2 (d)(2) and for the accrediting authority's management and technical staff as set forth in subsection 6.3.3.1(i).				
253.	6.3.3.1.3(b)(7) the policies and procedures established to maintain document control.				
254.	6.3.3.1.3(b)(8) the procedures and policies to implement the accreditation process.				
255.	6.3.3.1.3(b)(9) the procedures and policies for dealing with appeals, complaints and disputes by laboratories.				

	NELAC Requirements of an Accrediting Authority				
	AA: Date:	**Yes**	**No**	**NA**	**Document Location/Comments**
256.	6.3.4 (a)(1) For all changes in the accrediting authority's environmental laboratory accreditation program listed below, the NELAP Director shall be notified of changes to: the authority to accredit laboratories as stated in the statutes, regulations and promulgating instructions establishing and governing the accrediting authority's environmental laboratory accreditation program.				
257.	6.3.4 (a)(2) For all changes in the accrediting authority's environmental laboratory accreditation program listed below, the NELAP Director shall be notified of changes to: the organizational structure including key personnel.				
258.	6.3.4 (a)(3) For all changes in the accrediting authority's environmental laboratory accreditation program listed below, the NELAP Director shall be notified of changes to: the rules, regulations, policies, guidance documents and standard operating procedures.				
259.	6.3.4 (a)(4) For all changes in the accrediting authority's environmental laboratory accreditation program listed below, the NELAP Director shall be notified of changes to: the mailing address and office location, telephone and telefacsimile numbers and electronic mail address.				
260.	6.3.4 (a)(5) For all changes in the accrediting authority's environmental laboratory accreditation program listed below, the NELAP Director shall be notified of changes to: the contractual arrangements, including contractor's personnel, for laboratory accreditation activities contracted out under authority of subsection 6.2 (c).				
261.	6.3.4 (b) The notification to the NELAP Director shall be made within 30 calendar days of the change taking place in the accrediting authority's environmental laboratory accreditation program.				
262.	6.8 (a) The accrediting authority shall have requirements for controlling the ownership, use and display of the accrediting authority's NELAP accreditation documents and for controlling the manner in which an accredited laboratory may refer to its NELAP accreditation and/or use of the NELAC/NELAP logo.				
	6.8 (b) The accrediting authority has arrangements to require NELAP accredited laboratories choosing to use the accrediting authority's name, making reference to its NELAP accreditation status and/or using the NELAC/NELAP logo in any catalogs, advertising, business solicitations, proposals, quotations, laboratory analytical reports or other materials to:				
263.	6.8(b)(1) distinguish between proposed testing for which the NELAP accredited laboratory is accredited and the proposed testing for which the NELAP accredited laboratory is not accredited.				
264.	6.8(b)(2) include the NELAP accredited laboratory's accreditation number or other identifier.				
265.	6.8(c) The accrediting authority has arrangements to require the NELAP accredited laboratories upon suspension, revocation or withdrawal of their NELAP accreditation to:				

	NELAC Requirements of an Accrediting Authority				
	AA: Date:	**Yes**	**No**	**NA**	**Document Location/Comments**
266.	6.8(c)(1) discontinue use of all catalogs, advertising, business solicitations, proposals, quotations, laboratory analytical results or other materials that contain reference to their past NELAP accreditation status and/or display the NELAC/NELAP logo.				
267.	6.8(c)(2) return any certificates for NELAP accreditation to the accrediting authority.				
268.	6.8(d) The accrediting authority has arrangements to take suitable actions, including legal action, when incorrect references to the accrediting authority's NELAP accreditation, misleading use of the laboratory's NELAP accreditation status and/or unauthorized use of the NELAC/NELAP logo is found in catalogs, advertisements, business solicitations, proposals, quotations, laboratory analytical reports or other materials. .				

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